The medical system is strategic for women's liberation. It is the guardian of reproductive technology – birth control, abortion, and the means for safe childbirth. It holds the promise of freedom from hundreds of unspoken fears and complaints that have handicapped women throughout history. When we demand control over our own bodies, we are making that demand above all to the medical system. It is the keeper of the keys.

But the medical system is also strategic to women's oppression. Medical science has been one of the most powerful sources of sexist ideology in our culture. Justifications for sexual discrimination – in education, in jobs, in public life – ultimately rest on the one thing that differentiates women from men: their bodies. Theories of male superiority ultimately rest on biology.

Medicine stands between biology and social policy, between the "mysterious" world of the laboratory and everyday life. It makes public interpretations of biological theory; it dispenses the medical fruits of scientific advances. Biology discovers hormones; doctors make public judgments on whether "hormonal unbalances" make women unfit for public office. More generally, biology traces the origins of disease; doctors pass judgment on who is sick and who is well.

Medicine's prime contribution to sexist ideology has been to describe women as sick, and as potentially sickening to men.

COMPLAINTS AND DISORDERS

THE SEXUAL POLITICS OF SICKNESS

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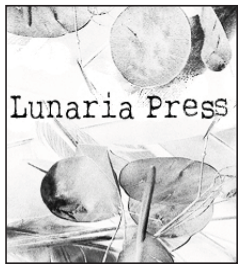

Introduction

A Perspective on the Social Role of Medicine

The medical system is strategic for women's liberation. It is the guardian of reproductive technology – birth control, abortion, and the means for safe childbirth. It holds the promise of freedom from hundreds of unspoken fears and complaints that have handicapped women throughout history. When we demand control over our own bodies, we are making that demand above all to the medical system. It is the keeper of the keys.

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Of course, medicine did not invent sexism. The view that women are "sick," or defective versions of men, is as old as Eden. In the traditions of Western thought, man represents wholeness, strength, and health. Woman is a "misbegotten male," weak and incomplete. Since Hippocrates bewailed women's "perpetual infirmities," medicine has only echoed the prevailing male sentiment: it has treated pregnancy and menopause as diseases, menstruation as a chronic disorder, childbirth as a surgical event. At the same times woman's "weakness" has never barred her from heavy labor; her "instability" has never disqualified her from total responsibility for child raising.

In the psychology of sexism, contempt is always mixed with *fear*. If woman is sick, there is always the danger that she will infect men. Menstrual and postpartum taboos, which serve to protect males from female "impurity," are almost universal in human cultures and, not surprisingly, are strictest in the most patriarchal societies. Historically, medicine ratified the dangers of women by describing women as the source of venereal disease. Today, we are most likely to be viewed as mental health hazards – emasculating men and destructively dominating children.

Medicine inherited from religion its role as a guardian of sexist ideology. Early Christian writings are filled with denunciations of women as men's spiritual inferiors, their contagious sexuality capable of dragging men down into the mire of passion. "Every woman ought to be filled with shame at the thought that she is

a woman," wrote Clement of Alexandria (c.150 – 215). And St. John Chrysostom (c.347-407) – an early church father who once pushed a woman off a cliff to demonstrate his immunity to temptation – said, "Among all the savage beasts none is found so harmful as woman." In medieval Europe, it was the Church that regulated women's reproductivity, legislating on abortion and contraception, proscribing the use of herbs to ease the pain of labor. It banned women from the sacraments during menstruation and the weeks following delivery. It controlled the licensing of midwives and, in some cases, that of physicians generally.

American Protestantism also resisted the legalization of contraception and abortion and even the use of anesthesia in labor. But generally it took a more benign and paternalistic view of women. It granted them spirituality though only at the price of their sexuality. It granted them "equality" if they stayed within their "God-appointed sphere" of domestic life. And Protestantism, unlike Catholicism, was willing to join forces with science in discovering and upholding the "natural order" of things. Nineteenth-century religious leaders happily supplemented religious justifications of sexism with newly developed bio-medical ones. Gradually woman's supposed physical infirmities win out over her moral defects as the rational for male supremacy. The secularization of male domination has advanced rapidly in just the past few decades: contraception is legal *when dispensed by doctors*. Abortion is no longer a moral outrage but a matter "between a woman *and her doctor*."

Thus it is no accident that the women's liberation movement today* puts so much emphasis on health and "body" issues. Women are dependent on the medical system for the most basic control over their own reproductivity. At the same time, women's encounters with the medical system bring them face to face with sexism in its most unmistakeably crude and insulting forms.

Our motivation to write this pamphlet comes out of our own experiences as women, as health care consumers, and as activists in the women's health movement. In writing this, we have tried to see beyond our own experiences (and anger) and to understand medical sexism as a *social force* helping to shape the options and social roles of all women.

Our approach is largely historical. In the first sections of this pamphlet we attempt to describe medicine's contribution to the sexist ideology and sexual oppression in the late nineteenth and early twentieth centuries (approximately 1865 to 1920 though a few important medical books were written earlier). We chose to begin with this period because it witnessed a pronounced shift from a religious to a bio-medical rationale for sexism, as well as the formation of the medical profession as we know it – a male elite with a legal monopoly over medicine practice. We feel that this period provides a perspective essential for understanding our relation to the modern medical system. In the last two sections

*[Distributor's note: This pamphlet was originally written in the early 1970s. Whenever the authors speak of "today", bear this in mind.]

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Miscellaneous

Reverdy, Susan. *Sex O'Clock in America: Prostitution, White Slavery, and the Progressives and the Jews (1900-1917)*. Unpublished, 1973. Anti-Semitism and the anti-vice movement, and more.

Salmon, Lucy Maynard. *Domestic Service. New York: Macmillan, 1911*. The definitive historical and statistical study of servants in America. The dry facts are enlivened with a wealth of quotes from servants and mistresses.

Soper, George A. "The Curious Career of Typhoid Mary." In the magazine *The Diplomate* (December 1939). the story of her capture, by the man who captured her.

Walker, Stanley. "Typhoid Carrier #36." In *The New Yorker*, January 26, 1935. A sympathetic account of Typoid Mary's last years on North Brother Island.

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Education Department of the ILGWU, New York. *Garment Workers Speak*. the horrors of early twenteith century factory work– by the women who survived.

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Szasz, Thomas S. "The Sane Slave: A Historical Note on the Use of Medical Diagnosis as Justificatory Rhetoric." In *American Journal of Psychotherapy*, 25:2 (April 1971): 228-39. A discussion of Dr. Samuel Cartwright's medical theories about blacks.

Veith, Ilza. *Hysteria: A History of A Disease*. Chicago and London: The University of Chicago Press, 1965. A rich and detailed history.

Winslow, C.E.A. *The Evolution and Significance of the Modern Public Health Campaign*. New Haven: Yale University Press, 1923. A leading historian of public health considers the relationship of public health measure to scientific advance – noting on public health and society.

Nineteenth Century Medical Books on Women

Bliss, W.W. *Woman and Her Thirty-Years' Pilgrimage*. Boston: B.B. Russell, 1873.

Clarke, Edward H., M.D. *Sex in Education, or, a Fair Chance for the Girls*. Boston: James R. Osgood and Co., 1873. Reprint Edition 1972 by Arno Press, Inc. The famous diatribe against high education for women.

Dirix, M.E., M.D. *Woman's Complete Guide to Health*. New York: Townsend and Adams, 1869.

Hollik, F., M.D. *The Disease of Woman, Their Cause and Cure Familiarly Explained*. New York: T.W. Stong, 1849

Taylor, W.C., M.D. *A Physcian's Counsels to Woman in Health and Disease*. Springfeild: W.J. Holland & Co., 1871

Warner, Lucien C., M.D. *A Popular Treatise on the Function and Disease of Woman*. New York: Manhattan Publishing Company, 1874.

Home Economics and Sanitation

Campbell, Helen. *Household Economics*. New York: G.P. Putman's Sons, 1907. Post-germ theory treatise on the "science" of housekeeping.

Plunkett, H.M., Mrs. *Women, Plumbers and Doctors, or Household Sanitation*. New York: Appleton, 1885. Spells out the woman's responsibilty as sanitation officer in her own home, filled with fears of contagion from the poor.

Wright, Julia McNair. *The Complete Home: An Encyclopedia of Domestic Life and Affairs*. Philadelphia: P.W. Zeigler and Co., 1881. Wherein "Aunt Sophronia" advises her neices on how to manage the house, i.e., the servants.

Birth Control

Complete Works of Theodore Roosevelt. Vol. 19. New York: Charles Scribner's Sons, 1926. See Chapter Twelve, "Birth Reform from the Positive, Not the Negative Side," pp. 152-66

we attempt to apply that perspective to our present situation and the issues that concern us today.

We want to make clear that we have not tried to write a definitive social history of women and medicine in America, nor have we tried to make an objective evaluation of women's health or the quality of their medical treatment, past or present. Our interest is primarily in medical *ideas* about women, particularly the ideas and themes that struck a chord with *us* and seemed to explain our own condition. We trust that you will take what we have done not as a final statement but as an invitation to go much further.

In this pamphlet our focus is on women and their relation to medical practice and medical beliefs. But the context goes beyond medicine itself and embraces all oppressed groups. In the historical period we have studied, science in general was invoked to justify the social inequalities imposed by race and class as well as by sex. Industrial technology – plus the labor of millions of working people – was creating the wealth of the business elite that still rules America. If technology could make some men rich and powerful, surely *science* could justify their power. Racism, like sexism, seemed to shift from the realm of prejudice into the light of "objective" science. Blacks and European immigrants were described as congenitally inferior to white Anglo-Saxon Protestants, having smaller brains, larger muscles, and a host of "inherited" social traits. Race and class oppression, like sexual oppression, were not undemocratic; they were only "natural."

During this transitional period morality was still mixed with science in the ideology of domination. Scientists believed that moral traits – like the supposed shiftiness of blacks or the disorderliness of Irish immigrants – were inheritable. Public health officials spoke of "God's sanitary laws," and doctors saw themselves as the moral, as well as physical, guardians of women. Today the transition is almost complete: science needs no assistance from the pulpit. When it passes judgment on the IQ of blacks, or on the prenatally determined psychological differences between the sexes, it is only being "objective." The fading of the last vestiges of religious moralism from scientific ideology has made it all the more mystifying, all the more effective as a potential tool for domination. We hope that the story presented here will contribute to people's confidence and ability to see through the "rational," "scientific" disguise of power.

radical or a feminist.

Pivar, David J. *The New Abolitionism: The Quest for Social Purity (1876-1900).* Ann Arbor: University Microfilms, 1965. Traces the anti-slavery movement up to later social reform movements sprear-headed by middle- and upper-class women. A valuable source for us.

Rosenberg, Charles E. *The Cholera Years.* Chicago: The University of Chicago Press, 1962. The only public health history we know of that puts public health in historical and social perspective. A key source to us.

Smith-Rosenberg, Carroll. "The Hysterical Woman: Sex Roles in Nineteenth Century America." In *Social Research*, 39:4 (Winter 1972), 652-78. An excellent article that focuses on the doctor-patient relationship.

Vicinus, Marth, ed. *Suffer and Be Still: Women in the Victorian Age*. Bloomington: Indiana University Press, 1972. A scholarly anthology ranging from menstruation to women in art.

Zaretsky, Eli. "Capitalism, the Family and Personal Life." In *Socialist Revolution*, 3:13 and 14 (January - April 1973) 69-125. Sweeping historical analysis of the relationship between women's roles and the economic system.

III. If you want to do further research, you might want to look at some of the following books and articles. Some are widely available; other are obscure (We used the New York Academy of Medicine Library and the Main Branch of the New York Public Library):

General Social History

Banks, J.A., and Banks, Olive. *Feminism and Family Planning in Victorian England.* New York: Schocken Books, 1964. Really much broader than the title suggests. Describes the development of the "lady" and her social role.

Crow, Duncan. *The Victorian Woman*. New York: Stein and Day, 1971. Wide-ranging and fun to read. The emphasis is on English women.

Hofstdter, Richard. *The Age of Reform*. New York: Alfred A. Kropf, 1965

Mann, Arthur. *Yankee Reformers in the Urban Age.* Combridge, Mass.: Belknap Press, 1954.

The above books by Hofstadter and Mann proved some general historical background on urban life and politics in the late nineteenth and early twentieth century.

Histories of Medicine, Public Health, and Disease

Graham, Harvey. *Eternal Eve: The Mystery of Birth and the Customs that Surround It.* London: Hutchinson and Co., 1960. A totally uncritical history of gynecology and obstetrics.

Freud, Sigmund. *Dora – An Analysis of a Case of Hysteria.* New York: Collier Books, 1963. The discovery that hysteria was a mental disorder; the begining of psycholoanalysis.

Rosebury, Theodor. *Microbes and Morals: The Strange Story of Venereal Disease.*

Bibliography

I.For more perspective on medical sexism, in contemporary society, you should read:

Chesler, Phyllis. *Women and Madness*. New York: Doubleday, 1972. On sexist theory and practice of psychiatry. A best-seller for good reasons.

Frankfort, Ellen. *Vaginal Politics*. New York: Quadrangle Books, 1972. Wide-ranging, ludic report on medical sexism today from abortion to cancer and sexuality.

Lennane, K. Jean, and Lennane, R. John. "Alleged Pyschogenic Disorders In Women – A Possible Manifestation of Sexual Prejudice." In *New England Journal of Medicine*, 288 (1973): 288. Two doctors attack the medical profession's tendency to diagnose women's illness as psychosomatic.

Scully, Diane, and Bart, Pauline. "A Funny Thing Happened on the Way to the Orifice: Women in Gynecology Textsbooks." In *American Journal of Sociology*, 78 (1973): 1045. Long overdue feminist study of the textsbooks gynecologists read and write.

Seaman, Barbara. *Free and Female*. New York: Coward-McCann, 1972. See especially the chapter on gynecologists. Fun to read and full of information.

Szasz, Thomas S. *The Myth of Mental Illness*. New York: Dell, 1961. Psychiatry exposed as an agency of social control. A classic.

II. If you want to read more about the history, these are some of the sources we found especially useful, for their interpretations as well as for their information:

Barker-Benfield, Ben. "The Spermatic Economy: A Nineteenth Century View of Sexuality." In *Feminist Studies*, 1:1 (Summer, 1972). Fascinating study of male motivation in gynecology and the relationship between medical ideas and the economic basis of society – by a truly feminist male historian.

Cott, Nancy F., ed. *Root of Bitterness: Documents of the Social History of American Women*. New York: Dutton, 1972. See especially the section, "Sexuality and Gynecology in the Nineteenth Century."

Frutcher, Rachel Gillett. "Women's Weakness: Consumption and Women in the Nineteenth Century." Unpublished paper, 1973. The source of all our information on women and TB.

Gilman, Charlotte Perkins. *The Yellow Wallpaper*. With an afterward by Elaine R. Hedges. Old Westbury, New York: The Feminist Press, 1973. Great as literature as well as a socially penetrating description of female invalidism.

Highman, John. *Strangers in the Land: Patterns of American Nativism (1860-1925)*. New York: Atheneum,1 1971. The chapter on the development of racism is full of insight into the ideological uses of "science"

Kennedy, David M. *Birth Control in America: The Career of Margaret Sanger*. New Haven; Yale University Press, 1970. Excellent as a biography and a social history. Shows (with a minimum of sexism) why Margaret Sanger was not a

Women and Medicine in the Late Nineteenth and Early Twentieth Centuries

The Historical Setting

Women are not a "class"; they are not uniformly oppressed; they do not all experience sexism in the same ways. In the period between 1865 and 1920, class differences among American women were particularly sharp: the lifestyle, manners, and expectations of upper-class women had little in common with those of working-class women. This was a period of rapid industrialization, urbanization, and class polarization, affecting all Americans. In the cities – and here we are concerned only with the urban world, where medical trends were set – two classes, essentially new to American society, were coming to dominate the scene: an upper middle class whose wealth was based on business and industry and an industrial working class whose labor provided that wealth.*

The social roles of women in these two classes were almost diametrically opposed. For the affluent women, society prescribed lives of leisured indolence; for the working-class women, back-breaking toil. No *single* ideology of sexism, could embrace both realities or justify both social roles. Hence, bio-medical thought had to provide two distinct views of women: one appropriate to the upper middle class (and the middle class that aspired to an upper-middle-class lifestyle), and one appropriate to poor and working-class women.

It was as if there were different human species of females. Affluent women were seen as inherently sick, too weak and delicate for anything but the mildest pastimes, while working-class women were believed to be inherently healthy and robust. The reality was very different. Working-class women, who put in long hours of work and received inadequate rest and nutrition, suffered far more than wealthy women from contagious diseases and complications of childbirth.

But doctors reversed the causality and found the soft, "civilized" life of the upper classes more health-threatening and medically interesting than hard work and privation. Dr. Lucien Warner, a popular medical authority,** wrote in 1874, "It is not then hard work and privation which make the women of our country invalids, but circumstances and habits intimately connected with the so-called blessings of wealth and refinement." In an article on the servant shortage, a contemporary journalist in *The Nation* (1912) wrote:

> It might be a very good thing for a woman's health to sweep her room, and make her bed, and dust her parlor, and get her dinner; but the attenuation of her physical energies has been carried so far by

*It is important not to project current conceptions of class onto the classes of the late nineteenth and early twentieth centuries. The urban working class of the time bore no relation to today's Archie Bunker image of the working class (which is inaccurate anyway.) Mostly European immigrants, they were extremely poor, even by the standards of the day. They occupied somewhat that same social status as poor urban blacks do today.

** We have chosen to quote only those doctors who seemed to us to be representative, based on our reading of popular gynecology books in the collection of the New York Academy of Medicine.

> civilization that it will take a generation or two of golfing, boating and bathing to give her sex back the strength of old days, when the domestic virtues went hand in hand with domestic labors.

Someone had to be well enough to do the work, though, and working-class women, Dr. Warner noted with relief, were *not* invalids: "The African negress, who toils beside her husbands in the field of the south, and Bridget, who washes, and scrubs and toils in our homes in the north, enjoy for the most part good health, with comparative immunity from uterine disease."

But if "Bridget" and "Beulah" were not too sick to do the housework and the factory work, they were unhealthy – at least to the upper-class observers who described immigrants and blacks as congenitally dirty and possibly contagious. The working-class woman might not faint, or get "uterine disease," but she undoubtedly harbored germs or typhoid, cholera, or venereal disease. Furthermore, as a breeder, she was seen as a public health threat, undermining the American "race" with her "inferior" offspring.

Beneath all this ran two ancient strands of sexist ideology: contempt for women as weak and defective, and fear of women as dangerous and polluting. Here we see the two separated, and applied to wealthy and poor females respectively. Upper- and upper-middle-class women were "sick"; working-class women were "sickening." In the sections that follow we deal first with the upper-middle-class or "sick" women, their relation to the medical system and the ideology applied to them, and then we go on to the bio-medical views of the working class, and working-class women in particular.

The "Sick" Women of the Upper Class

The affluent woman normally spent a hushed a peaceful life indoors, sewing, sketching and reading romances, planning menus and supervising servants and children. Her clothes, a sort of portable prison of tight corsets and long skirts, prevented activity any more vigorous than a Sunday stroll. Society agreed that she was frail and sickly. Her delicate nervous system had to be shielded as carefully as her body, for the slightest shock could send her reeling off to bed. Elizabeth Barrett Browning, for example, although she was an extraordinarily productive woman, spend six years in bed following her brother's death in a sailboat accident.

But not even the most sheltered woman lived in a vacuum. Just outside the suffocating world of the parlor and the boudoir lay a world of industrial horror. This was the period of America's industrial revolution, a revolution based in the ruthless exploitation of working people. Women, and children as young as six, worked fourteen-hour days in factories and sweatshops for sub-subsistence wages. Labor struggles were violent bordering, at times, on civil wars. For businessmen, too, survival was a bitter struggle: you squeezed what you could out of the workers, screwed the competition, and the devil take the hindmost. Fortunes were made and destroyed overnight, and with them rode the fates of

from occupations that involve concentration and responsibility. Say that it is unnoticeable and that we are as consistently healthy as males are supposed to be, and all women will be required to lift the same weights and work the same long hours required of men regardless of the degree of discomfort experienced. Say that the last months of pregnancy are difficult, and we will be fired at the first signs of swelling. Say that there is "nothing unhealthy about being pregnant," and we will be held to eight hours a day, five days a week. There are real dangers – for all of us – in either understating or exaggerating our needs as women.

There is no "correct line" on our bodies. There is no way to determine our "real" needs, our "real" strengths and liabilities, in a sexist society – any more than there is a way to understand what "female nature" may really be. How can we "know ourselves" when the only images we have of ourselves are images cast by an oppressive society?

There is no way for us to come to terms with our own bodies, in whatever female "subcultures" we may attempt to create, because, when you come right down to it, our bodies are not the issue. Biology is not the issue. The issue is power, in all the ways it affects us. We could debate endlessly, for example, about whether premenstrual tension is "real" or psychosomatic, whether the last months of pregnancy are invigorating or debilitating. But the real question is: Who decides the consequences? We could clash over the culture of childbirth, whether or not having test-tube babies would be "healthier" and more liberating than natural childbirth. But who decides what options will actually be available to us? More important, who controls the social context of childbirth – the availability of abortion at one end and of day care at the other?

This is not to say that we do not need more hard information about our biology and about our health needs. We do. We need to know much more about occupational health hazards specific to women, about actual emotional patterns accompanying menstruation and pregnancy, about the potential hazards of various contraceptive methods, and about many other areas ignored or distorted by medicine. But in our concern to understand more about our own biology, for our own purposes, we must never lose sight of the fact that it is not our *biology* that oppresses us – but a social system based on sex and class domination.

This, to us, is the most profoundly liberating feminist insight – the understanding that our oppression is socially, and not biologically, ordained. To act on this understanding is to ask for more than "control over our own bodies." It is to ask for, and struggle for, control over the social options available to us, and control over all the institutions of society that now define those options.

allowed to experience beauty at childbirth – while thousands of women do not have adequate prenatal nutrition, or have not had access to the means of avoiding unwanted childbearing – is worse than naive: it's cruel.

It is easy enough to say that we must recognize the diversity of women's needs, and that the demands we make of the medical system must represent the broadest possible range of women's experience. But once we begin to talk about needs beyond the most minimal survival services (contraception, cancer screening, etc.), we are no longer on very firm ground. How much of our "need" is manufactured, and how much is real? For example, the medical handling of pregnancy in our culture undoubtedly contributes to our anxieties about pregnancy, and anxiety can transform a minor discomfort into an urgent need for medical attention. The "need" is real enough at the time, but in a sense it is artificial. Manufactured to enhance our dependency on the medical system. Or, more commonly, our very ignorance of our bodies sometimes sends us in search of information and reassurance when no real care is necessary – another case of manufactured dependency.

On the other hand, for all our anger at being dismissed as "psychosomatic" cases when we really do feel sick, we cannot rule out the possibility that many women use sickness as an escape from their oppression as workers and wives. They are not being dishonest, or faking. Our culture encourages people to express resistance as "illness," just as it encourages us to view overt rebellion as "sick." The oppression is real; the resistance is real; but the sickness is manufactured.

Just how "sick" are we then as women? How much of our dependance on the medical system is biological necessity, and how much is social artifice? We spoke before of the contradiction between our rejection of medical ideology and our real dependance on medical technology. But how much of that dependency *is* real? Have we been so blinded by the ideology (which labels us sick, one way or another) that we cannot define the dependency?

The women's movement has been totally ambivalent about this issue. There are feminists who would deny that we have any special liabilities as women: to them menstrual cramps, nausea in pregnancy, and all the rest are culturally induced, "curable" with a dose of consciousness-raising and a short course in physiology. However, there are other feminists who seem totally preoccupied with the agonies of menstruation, postpartum depression, or menopause. And there are some who believe that childbirth is so dangerous and degrading that we should abstain until test-tube babies are available. And there are feminists who believe that childbirth is so healthy and gratifying that it is the peak experience of a woman's life. We seem to alternate between accusing the medical system of treating us as if we were sick and accusing them of not appreciating how sick we are!

The trouble is that whatever we say can be, and is, used against us. Say that menstruation is painful and distressing and women will be arbitrarily barred

thousands of smaller businessmen.

The genteel lady of leisure was not just an anomaly in an otherwise dog-eat-dog world. She was as much a product of that world as her husband or his employees. It was the wealth extracted in that harsh outside world that enabled a man to afford a totally leisured wife. She was the social ornament that proved a man's success: her idleness, her delicacy, her childlike ignorance of "reality" gave a man the "class" that money alone could not provide. And it was the very harshness of the outside world that led men to see the home as a refuge – "a sacred place, a vestal temple," a "tent pitch'd in a world not right," presided over by a gentle, ethereal wife. Among the affluent classes, the worlds of men and women drifted further and further apart, with divergent standards of decorum, of health, of morality itself.

There were exceptional women in the upper classes – women who rebelled against the life of enforced leisure, the limitations of meaningful work – and it is these exceptional women who are usually remembered in history books. Many became women's rights activists or social reformers. A brave few struggled to make their way in the professions. And toward the end of the nineteenth century a growing number were demanding, and getting, college educations. But the majority of upper- and upper-middle-class women had little chance to make independent lives for themselves; they were financially at the mercy of husbands and fathers. They had to accept their roles – outwardly at least – and remain dutifully housebound, white-gloved and ornamental. Of course, only a small minority of urban women could afford a life of total leisure, but a great many more women in the middle class aspired to it and did their best to live like "ladies."

The Cult of Female Invalidism

The boredom and confinement of affluent women fostered a morbid cult of hypochondria - "female invalidism" – that began in the mid-nineteenth century and did not completely fade until the late 1910s. Sickness pervaded upper- and upper-middle-class female culture. Health spas and female specialists sprang up everywhere and became part of the regular circuit of fashionable women. And in the 1850s a steady stream of popular home readers by doctors appeared, all on the subject of female health. Literature aimed at female readers lingered on the romantic pathos of illness and death; popular women's magazines featured such stories as "The Grave of My Friend" and "Song of Dying." Paleness and lassitude (along with filmy white gowns) came into vogue. It was acceptable, even fashionable, to retire to bed with "sick headaches," "nerves," and a host of other mysterious ailments.

In response, feminist writers and female doctors expressed their dismay at the chronic invalidism of affluent women. Dr. Mary Putnam Jacobi, an outstanding woman doctor of the late nineteenth century, wrote in 1895:

> . . . it is considered natural and almost laudable to break down under

> all conceivable varieties of strain – a winter dissipation, a houseful of servants, a quarrel with a female friend, not to speak of more legitimate reasons. . . . Women who expect to go to bed every menstrual period expect to collapse if by chance they find themselves on their feet for a few hours during such a crisis. Constantly considering their nerves, urged to consider them by well-intentioned but short-sighted advisers, they pretty soon become nothing but a bundle of nerves.

Charlotte Perkins Gilman, a feminist writer and economist, concluded bitterly that American men "have bred a race of women weak enough to be handed out like invalids; or mentally weak enough to pretend they are – and to like it."

It is impossible to tell, in retrospect, how sick upper-middle-class women really were. Life expectancies for women were slightly higher than for men though the difference was nowhere near as great as it is today.

It is true, however, that women – *all* women – faced certain risks that men did not share, or share to the same degree. First were the risks associated with childbearing, which were all the greater in an age of primitive obstetrical technique when little was known about the importance of prenatal nutrition. In 1915 (the first year in which national figures are available) 61 women died for every 10,000 lives babies born, compared to 2 per 10,000 today, and the maternal mortality rates were doubtless higher in the nineteenth century. Without adequate, and usually without any, means of contraception, a married woman could expect to face the risk of childbirth repeatedly through her fertile years. After each childbirth a woman might suffer any number of gynecological complications, such as a prolapsed (slipped) uterus or irreparable pelvic tear, which would stay with her for the rest of her life.

Another special risk to women came with tuberculosis [TB], the "white plague." In the mid-nineteenth century, TB raged at epidemic proportions, and it continued to be a major threat until well into the twentieth century. Everyone was affected, but women, especially young women, were particularly vulnerable, often dying at rates twice as high as those of men of their age group. For every hundred women aged twenty in 1865, more than five would be dead from TB by the age of thirty, and more than eight would be dead by the age of fifty. (It is now believed that hormonal changes associated with puberty and childbearing accounted for the greater vulnerability of young women to TB.)

The danger of childbearing, and of TB, must have shadowed women's lives in a way we no longer know. But these dangers cannot explain the cultural phenomenon of "female invalidism" which, unlike TB and maternal mortality, was confined to women of a particular social class. The most important legitimization of this fashion came not from actual dangers faced by women but from the medical profession.

The medical view of women's health not only acknowledged the specific risks associated with reproductivity, it went much further: it identified *all* female functions as *inherently* sick. Puberty was seen as a "crisis" throwing the entire

and who cannot function fully as women until they have them.

It is only in the context of our ambivalence to the medical system that we can assess the historic importance of the self-help movement.

Self help, which emphasizes self-examination and self-knowledge, is an attempt to seize the *technology* without buying the ideology. Self help has no limits beyond those imposed by our imagination and our resources. It *could* expand far beyond self-examination to include lay (though not untrained) treatment for many common problems – lay prenatal and delivery assistance, lay abortions, and so on. But if our imaginations are unlimited, our resources *are* limited. If we are concerned with the care of *all* women – and not just those with the leisure for self-help enterprises – for *all* their problems – and not just the uncomplicated disorders of youth – then we are once again up against the medical system with its complex and expensive technology.

In fact, it is in precisely this confrontation that self help proves its worth. It arms us to demand what we need, not what someone thinks we should get. It gives us a vision of what medical care *could* mean – a system in which needs are not met at the price of dignity.

Self help is not an alternative to confronting the medical system with the demands for reform of existing institutions. Self help, or more generally, self knowledge, is critical to that confrontation.

Health is an issue for women which has the potential to cut across class and race lines. The medical system, more than any other institution of American society, reduces us to a biological category, stripped of our occupations, lifestyles, and individualities. There is very little danger today that middle-class women will relate to poor and working-class women purely as missionaries or "organizers" for health reforms because middle-class women are becoming so acutely aware of their *own* oppression in the medical system. The growth of feminist consciousness gives us the possibility, for the first time, of a truly egalitarian, mass women's health movement.

But it would be naive to assume that, because all women experience medical sexism, all women have the same needs and priorities at this time. Class differences in the medical treatment of women may not be as sharp as they were eighty years ago, but they are still very real. For black women, medical racism often overshadows medical sexism. For poor women of all ethnic groups, the problem of how to get services of any kind often overshadows all qualitative concerns. And for all of us except the most affluent, there is the constant worry about whether the care we are getting meets minimal standards of technical competence – never mind the amenities of dignity and courtesy.

A movement that recognizes our biological similarity but denies the diversity of our priorities cannot be a women's health movement, it can only be *some women's* health movement. For example, it is important to demand a more dignified and participatory approach to childbirth. But to focus on the demand that we be

From Here On: Concluding Thoughts

The medical system is not just a service industry. It is a powerful instrument of social control, replacing organized religion as a prime source of sexist ideology and an enforcer of sex roles. Certainly, it is not the *only* haven of institutional sexism in our society – the educational system may be equally important or even more important. But it has the unique authority to judge who is sick and who is well, who is fit and who is unfit. The presumed scientific basis of medicine lends credibility to these judgments, yet as we have seen, the judgments themselves have no consistent basis in biology. At one time, women of one class were judged uniformly sick while women of another class were uniformly well, though potentially sickening to others. Today we are all well, at least well enough to work; our sickness is "only mental." Our social roles, and not our innate biology, determined our state of health. Medicine does not invent our social roles, it merely interprets them to us as biological destiny.

As feminists we are totally antagonistic to the medical system as a source of sexist ideology. But at the same time, we are totally dependent on medical *technology* for some of the most basic and primitive freedoms we require as women – freedom from unwanted pregnancies, freedom from chronic disability. We may be repelled by the crude sexism we encounter in doctors, we may be enraged by the sophisticated sexism passed off as medical theory, but we have nowhere else to turn for abortions, diaphragms, antibiotics, and essential surgery.

Our sheer physical dependencies on medical technology makes the medical system all the more powerful as a source of sexist ideology. They have us, so to speak, by the ovaries. All too often, women have humbly excepted the ideological judgments ("you are sick, silly, hysterical, inadequate," etc) as the price of whatever technological freedoms they could wrest from the system. Now that we have come to take these freedoms just a little bit for granted, we sometimes lean too far the other way – rejecting the technology itself because we cannot stomach the ideological wrapping.

So we seem to be caught in a contradiction: there is something in the medical system we want, that we cannot live without, but is there any way to get it on our own terms? When we make demands of the medical system, or of a particular health institution, just what is it that we want? Do we want just "more services" – when every one of them is loaded with the message of oppression? When these services may have little to do with our own needs, and may in fact discount our real needs or substitute medically manufactured needs?

Clearly, our demands must go beyond the merely quantitative. We want more than "more"; we want a new *style*, and we want a new *substance* of medical practice as it relates to women. And yet we must never get so hung up on the ideological niceties that we forget that "more" alone is still crucial– an issue of survival – for millions of women who still lack the most routine care and preventative services,

female organism into turmoil. Menstruation – or the lack of it – was regarded as pathological throughout a woman's life. Dr. W.C. Taylor, in his book *A Physician's Counsels to Woman in Health and Disease* (1871), gave a warning typical of those found in popular health books of the time:

> We cannot too empathetically urge the importance of regarding these monthly returns as periods of ill health, as days when ordinary occupations are to be suspended or modified. . . . Long walks, dancing, shopping, riding and parties should be avoided at this time of month invariably and under all circumstances. . . Another reason why every woman should look upon herself as an invalid once a month, is that the monthly flow aggravates any existing affection of the womb and readily rekindles the expiring flames of disease.

Similarly a pregnant woman was "indisposed," and doctors campaigned against the practice of midwifery on the grounds that pregnancy was a disease and demanded the care of a doctor. Menopause was the final, incurable ill, the "death of the woman in the woman."

Women's greater susceptibility to TB was seen as proof of the inherent defectiveness of female physiology. Dr. Azell Ames wrote in 1875: "It being beyond doubt that consumption [TB] . . . is itself produced by the failure of the [menstrual] function in the forming girls . . . ones has been the parent of the other with interchangeable priority." Actually, as we know today, it is true that consumption may result in suspension of the menses. But at that time consumption was blamed on woman's nature and on her reproductive system. When men were consumptive, doctors sought some environmental factor, such as over-exposure, to explain the disease. But in popular imagery, consumption was always effeminate: novels of the time usually featured as male consumptives only such "effete" types as poets, artists, and other men "incompetent" for serious masculine pursuits.

The association of TB with innate feminine weakness was strengthened by the fact that TB is accompanied by an erratic emotional pattern in which a person may behave sometimes frenetically, sometimes morbidly. The behavior characteristic of the disease fit expectations about woman's personality, and the look of the disease suited – and perhaps helped to create – the prevailing standards of female beauty. The female consumptive did not lose her feminine identity, she embodied it: the bright eyes, translucent skin, and red lips were only an extreme of traditional female beauty. A romantic myth rose up around the figure of the female consumptive and was reflected in portraiture and literature: for example, in the sweet and tragic character of Beth, in *Little Women*. Not only were women seen as sickly – sickness was seen as feminine.

The doctor's view of women as innately sick did not, of course, *make* them sick, or delicate, or idle. But it did provide a powerful rationale against allowing women to act in any other way. Medical arguments were used to explain why women should be barred from medical school (they would faint in anatomy

lectures), from higher education altogether, and from voting. For example, a Massachusetts legislator proclaimed:

> Grant suffrage to women, and you will have to build insane asylums in every county, and establish a divorce court in every town. Women are too nervous and hysterical to enter into politics.

Medical arguments seemed to take the malice out of sexual oppression: when you prevented a woman from doing anything active or interesting, you were only doing this for her own good.

The Doctor's Stake in Woman's Illness

The myth of female frailty, and the very real cult of female hypochondria that seemed to support the myth, played directly to the financial interests of the medical profession. In the late nineteenth century and early twentieth centuries, the "regular" AMA doctors (member of the American Medical Association – the intellectual ancestors of today's doctors) still had no legal monopoly over medical practice and no legal control over the number of people who called themselves "doctors." Competition from lay healers of both sexes, and from what the AMA saw as an excess of formally trained male physicians, had the doctors running scared. A good part of the competition was female: women lay healers and midwives dominated the urban ghettos and the countryside in many areas; suffragists were beating on the doors of medical schools.

For the doctors, the myth of female frailty thus served two purposes. It helped them to disqualify women as healers and, of course, it made women highly qualified as patients.* In 1900 there were 173 doctors (engaged primarily in patient care) per 100,000 population, compared to 50 per 100,000 today. So, it was in the interests of the doctors to cultivate illnesses of their patients with frequent home visits and drawn-out "treatments." A few dozen well-healed lady customers were all that a doctor needed for a successful urban practice. Women –at least, women whose husbands could pay the bills – became a natural "client caste" to the developing medical profession.

In many ways, the upper-middle-class woman was the ideal patient: her illnesses – and her husband's bank account – seemed almost inexhaustible. Furthermore, she was usually submissive and obedient to the "doctor's orders." The famous Philadelphia doctor S. Wier Mitchell expressed his profession's deep appreciation of the female invalid in 1888:

> With all her weakness, her unstable emotionality, her tendency to morally warp when long nervously ill, she is then far easier to deal with, far more amenable to reason, far more sure to be comfortable as a patient, than the man who is relatively in a like position. The reasons are far too obvious to delay me here, and physicians accustomed to dealing with both the sexes as sick people will be apt to justify my position.

*See *Witches, Midwives, and Nurses* by Barbara Ehrenreich and Deirdre English.

> Although such scientific evidence as exists clearly implicates organic causes, acceptances of a psychogenic origin has led to an irrational and ineffective approach to their management. Because these conditions affect only women, the cloudy thinking that characterizes the relevant literature may be due to a form of sexual prejudice.

The medical profession helped to create the popular notion of women as sickly in the first place: now it seems to have turned around and blamed the victim. Women patients are seen as silly, self-indulgent, and superstitious. Tranquilizers are used to keep us on the job when no quick medical fix can be found. How many times do we go to a doctor feeling sick and leave, after a diagnoses of "psychosomatic," feeling *crazy*?

In fact, the tendency of doctors to diagnose our complaints as psychosomatic shows that the medical view of women has not really shifted from "sick" to "well"; it has shifted from "physically sick" to "mentally ill." Today it is psychiatry, much more than gynecology, that upholds the sexist tenet of women's fundamental defectiveness. In classical psychoanalytic theory there is no such thing as a mentally well woman: the ambitious woman, not content to be a wife and mother, is seen as neurologically rejecting her femininity while the woman who is content to be with her family may be viewed as "infantile." Both are potentially sickening to those around them. The ambitious woman can be blamed for "emasculating" men, and the devoted mother can be blamed for "infecting" her sons with guilt and dependency. One result, as Phyllis Chesler has shown in her book *Women and Madness* (1972), is that women are more likely than men to be incarcerated in mental hospitals.

In general, the mainstream of psychological theory still upholds the view that middle-class women should stay at home, but for new reasons. In the past gynecology justified women's confinement to the home on the basis of women's supposed physical frailty and unfitness for outside pursuits. But now that middle-class women are finally sturdy enough to go out and work, they are being told that their children are too "delicate" to be left behind. Psychology has "discovered" that at least up to the age of three, children are totally dependent on one-on-one mothering! Send your child out to day care or hire a babysitter and you supposedly inflict a risk of lasting neurosis. (Pediatricians add that day care centers are notorious for spreading infectious disease.) So now it is the small child of the middle-class woman who has become too "delicate" for the "outside world" of day care, babysitters, and play groups. In contrast, the children of the welfare mother – who *ought* to be out working, according to current moral standards – is emotionally sturdy enough for the most alienating, industrial-style day care centers.

We can only marvel at the endless plasticity of a medical "science" that can adjust its theories for age, sex, or social class, depending on the needs of the time. Certainly, science, to be science, must change its theories to fit new data. What is amazing about medical "science" as it related to women that the theories change so neatly to fit the needs of the dominant, male ideology.

centuries, but we are struck even more by the differences. The situation of both doctors and women has changed drastically. For women, even in the upper middle class, the days of total leisure are over. More and more women work outside the home, and, within the home, the servants are gone. The woman who works outside holds down two jobs – that of a paid worker and that of an unpaid housekeeper and mother. Even the most affluent, "leisured" housewife is expected to be healthy and active at all times, able to chauffeur the kids around, manage the house, and perform as a gracious wife and hostess. In a statement that speaks for almost all of us, one working-class housewife told a medical sociologist, "Sometimes I'd like to be sick, but I don't have the time."

Doctors today don't seem to have the time for us to be sick anymore either. In the late nineteenth century there was, by present standard, an excess of doctors in the cities. Competition was fierce, and there was strong motivation to over-treat ill women and discover illnesses among well women. But in the early 1900s the medical profession won the legal right to control its own numbers – to set standards for medical schools, close "substandard" schools, etc* The closing of medical schools in the teens and twenties, followed by decades of AMA lobbying against Federal aid to medical schools, eventually produced the familiar doctor shortage. Only a few doctors base their practices on intimate care and give to a small number of rich people. Most spread their services fairly thinly over a large number of middle- and working-class people. The result is the ten-minute gynecological appointment, the fifteen-minute annual checkup (these are the actual times allotted in one of the New York area's largest and most reputable group practices), and during such quickie examinations the amount of patient/doctor dialogue is reduced to a minimum.

So for most of us, the intimate, paternalistic doctor-patient relationship of the nineteenth century is little more than a historical curiosity. Being sick is no longer consistent with our social roles nor is it a practical possibility, given the doctor shortage. Our medical image has come almost full circle from days of female invalidism. Because women have longer life expectancies than men, with lower risks of heart disease, stroke and lung cancer, *we* are considered the "stronger" sex, and the popular health books eagerly advise us how to keep our *husbands* alive and well. Just as surely as ever, our medical care does serve to enforce our social role, only now the role is to be workers (domestic or otherwise), not pampered invalids.

When a doctor cannot quickly pinpoint the organic cause of a woman's complaint, he is quick to suspect psychosomatic cause, i.e., malingering. A 1973 study written by two doctors, Jean and John Lennane, and published in a prestigious medical journal, concluded:

> Dysmenorrhea [menstrual cramps], nausea of pregnancy, pain in labor, and infantile behavioral disturbances are conditions commonly considered to be caused or aggravated by psychogenic factors.

*See *Witches, Midwives, and Nurses* for more on this phase

In Mitchell's mind women were not only easier to relate to, but sickness was the very key to femininity: "The man who does not know sick women does not know women."

Some women were quick to place at least some of the blame for female invalidism on the doctor's interests. Dr. Elizabeth Garrett Anderson, an American woman doctor, argued that the extent of female invalidism was much exaggerated by male doctors and that woman's natural functions were not really all that debilitating. In the working classes, she observed, work went on during menstruation "without intermission, and, as a rule, without ill effects." (Of course, working-class women could not have afforded the costly medical attention required for female invalidism.) Mary Livermore, a women's suffrage worker, spoke against "the monstrous assumption that woman is a natural invalid," and denounced "the unclean army of 'gynecologists' who seem desirous to convince women that they possess but one set of organs – and that these are always diseased." And Dr. Mary Putnam Jacobi put the matter most forcefully when she wrote in 1895, " I think, finally, it is in the increased attention paid to women, and especially their new function as lucrative patients, scarcely imaged a hundred years ago, that we find explanation for much of the ill-health among women, freshly discovered today. . . ."

The "Scientific" Explanation of Female Frailty

As a businessman, the doctor had a direct interest in a social role for women that encouraged them to be sick; as a doctor, he had an obligation to find the causes of female complaints. The result was that, as a "scientist," he ended up proposing medical theories that were actually justifications of women's social roles.

This was easy enough to do at the time: no one had a very clear idea of human physiology. American medical education, even at the best schools, put few constraints on the doctors' imaginations, offering only a scant introduction to what was known of physiology and anatomy and no training in rigorous scientific method. So doctors had considerable intellectual license to devise whatever theories seemed socially appropriate.

Generally, they traced female disorders either to women's inherent "defectiveness" or to any sort of activity beyond the mildest "feminine" pursuits – especially sexual, athletic, and mental activity. Thus promiscuity, dancing in hot rooms, and subjection to an overly romantic husband were given as the origins of illness, along with too much reading, too much seriousness or ambition, and worrying.

The underlying medical theory of women's weakness rested on what doctors considered the most basic physiological law: "conservation of energy." According to the first postulate of this theory, each human body contained a set quantity of energy that was directed variously from one organ or function to another. This meant that you could develop one organ or ability only at the expense of

other, particular, the sexual energies competed with the other organs for the body's fixed supply of vital energy. The second postulate of this theory – that reproductivity was central to a woman's biological life – made this competition highly unequal, with the reproductive organs in almost total command of the whole woman.

The implications of the "conservation of energy" theory for male and female roles are important. Let's consider them.

Curiously, from a scientific perspective, *men* didn't jeopardize their reproductivity by engaging in intellectual pursuits. On the contrary, since the mission of upper- and upper-middle-class men was to be doers, not breeders, they had to be careful not to let sex drain energy away from their "higher functions." Doctor's warned men not to "spend their seed" (i.e., the essence of their energy) recklessly, but to conserve themselves for the "civilizing endeavors" they were embarked upon. College youths were jealously segregated from women – except on rare sexual sprees in town – and virginity was often prized in men as well as women. Debilitated sperm would result from too much "indulgence," and this in turn would reproduce "runts," feeble infants, and girls.

On the other hand, because reproduction was woman's grand purpose in life, doctor's agreed that women ought to concentrate their physical energy internally, toward the womb. All other activity should be slowed down or stopped during peak periods of sexual use. At the onset of menstruation, women were told to take a great deal of bed rest in order to help focus their strength on regulating their periods – though this might take years. The more time a pregnant woman spent lying down quietly, the better. At menopause, women were often put to bed again.

Doctors and educators were quick to draw the obvious conclusion that, for women, higher education could be physically dangerous. Too much development of the brain, they counseled, would atrophy the uterus. Reproductive development was totally antagonistic to mental development. In a work entitled *Concerning the Physiological and Intellectual Weakness of Women*, the German scientist P. Meobius wrote:

> If we wish women to fulfill the task of motherhood fully she cannot possess a masculine brain. If the feminine abilities were developed to the same degree as those of the male, her maternal organs would suffer and we should have before us a repulsive and useless hybrid.

In the United States this thesis was sent forth most cogently by Dr. Edward Clarke of Harvard College. He warned, in his influential book *Sex in Education* (1873), that higher education was already destroying the reproductive abilities of American women.

Even if a woman should choose to devote herself to intellectual or other "unwomanly" pursuits, she could hardly hope to escape the domination of her uterus and ovaries. In *The Disease of Women* (1849), Dr. F. Hollick wrote: "The Uterus, it must be remembered, is the *controlling* organ in the female body, being

Notes on the Situation Today

One hundred years have passed since the heyday of wholesale ovariotomies, hysteria, and enforced invalidism. Medical theory no longer asserts that some women are congenitally sick, while others are potentially sickening. Yet in some important ways, the relationship between women and the medical system has changed very little, if at all.

Middle- and upper-class women are still a "client caste" to the medical profession. For a host of reasons connected with productivity women continue to visit doctors and enter hospitals far more frequently than men do. Pregnancy, if no longer prescribed explicitly as a disease, is still treated like a medical problem, in exactly the same settings and by exactly the some personnel used for the treatment of actual disorders. Childbirth is no longer a cause for lengthy confinement, but it is, more so than ever, an alienating, surgical event. Irregular menstruation is no longer viewed as calamitous, but doctors are more than willing to provide costly hormonal "cures." Menopause, while no longer an indication for terminal bed rest, is still described to medical students as "the most serious endocrinological disorder next to diabetes," "curable" of course, with expensive estrogen therapy. And while the riproaring frontier days of gynecological surgery may be gone forever, some doctors, such as Robert McCleery, in *One Life, One Physician* (1971), acknowledge that up to half of the hysterectomies performed in the United States (and perhaps a large proportion of radical mastectomies* performed anywhere) are unnecessary.

In fact, women's dependance on doctors (hence doctors' dependance on women) may have increased since 1900. Doctors moved in on each sexual or reproductive right as soon as it was liberated: they now control abortion and almost all reliable forms of contraception. Even sexual unresponsiveness – the "natural" condition of our great-grandmothers – has become a medical problem, with its own sex "clinics" and its own brand of medical specialists.

There are still profound class differences in women's relationship to the medical system. On the medical marketplace millions of women – far more than the statistically "poor" – cannot afford the most basic, preventative services, never mind the luxury items. The fragmented pattern of public health services for low-income women – here a VD clinic, there a Planned Parenthood clinic, almost nowhere a low-cost comprehensive care center – shows that they are still treated more as public health problems than as human beings needing individualized health care. For no groups is this truer than for black, Puerto Rican, and Chicana women. Once lumped together with Italians, Poles, and other immigrant groups as "inferior stock," Third World women now stand almost alone as the special target of such population control measures as involuntary sterilization.

We could go on tracing continuities from the nineteenth and early twentieth

*Mastectomy is the surgical removal of the breasts. Some mastectomies involve considerable damage to the muscles around the upper arm.

economics and "American values"; clubwomen set up discussion groups on ethical issues for young working women. According to home economics books of the time, even the woman who stayed at home had a missionary responsibility to instruct her servant in moral and sanitary matters and to prepare her to be a "good wife."

The upper-middle-class woman activist of the 1890s and early twentieth century had left her sisters far behind in their chaise longues, in sick rooms and health spas. She had rejected a medical ideology that defined her as sick and confined her to uselessness. But she seems to have won her "release" only on condition that she both remain true to the interests of her class and take on social roles that were essential extensions of the wife/mother role, as social worker or volunteer "uplifter." In these roles, bringing the gospel of hygiene, public health, home economics, etc. to the poor, she was necessarily patronizing, at times antagonistic, in her relations with poor women.

The issue of health – female health and family health – which potentially could have united women of different classes, now divided them into reformers on the one side and "problems" on the other. Upper-middle-class women did not turn against the medical profession that had imprisoned them and rejected poor women; they did not unite with poor women to create a movement which would demand a single standard of health and health care for all women. In the public health and birth control movements they allied themselves with doctors, against threats posed by the poor.

However, we do not want to leave the impression that upper-middle-class women were simply "led astray," by ideological consideration, from the task of building a health movement for and with all women. It is true that women of all social groups have potential unity round common biological experiences. And it is true that medical ideology – in the form of both "scientific" theory and popular beliefs – did its best to deny the commonality of women's experience and to separate women into sick (or vulnerable) and the sickening (or dangerous). But this ideology would never have been accepted by men – or women – of the upper classes if it hadn't been rooted in economic reality.

In many ways, the situation of women in the classes we have considered were complimentary. Upper-middle-class women would not have had the leisure to be invalids, or reformers, if it had not been for the exploitation of working-class people (including women and children); they would not have been free from household work if it had not been for the labor of domestic servants and the women working in factories manufacturing clothes and other household items that had once been made in the home. Medical myths and biological fears did not create the class differences among women; they only gave them "scientific" plausibility.

the most excitable of all, and so intimately connected, by the ramifications of its numerous nerves, with every other part." To other medical theorists, it was the ovaries that occupied center stage. This passage, written in 1870 by Dr. W.W. Bliss, is, if somewhat overwrought, nonetheless typical:

> Accepting, then, these views of the gigantic power and influence of the ovaries over the whole animal economy of the woman, – that they are the most powerful agents in all the commotions of her system; that on them rest her intellectual standing in society, her physical perfection, and all that lends beauty to those fine and delicate contours which are constant objects of admiration, all that is great, noble and beautiful, all that is voluptuous, tender and endearing; that her fidelity, her devotedness, her perpetual vigilance, forecast, and all those qualities of mind and disposition which inspires respect and love and fit her as the safest counselor and friend to man, spring from the ovaries, – *what must be their influence and power of the great vocation of woman and the august purposes of her existence when these organs have become compromised through disease!* Can the record of woman's mission on earth be otherwise than filled with tales of sorrow, sufferings, and manifold infirmities, all through the influence of these important organs?

This was not mere textbook rhetoric. In their actual medical practices, doctors found uterine and ovarian "disorders" behind almost every female complaint, from headaches to sore throats and indigestion. Curvature of the spine, bad posture, or pains anywhere in the lower half of the body could be the result of "displacement" of the womb, and one doctor ingeniously explained how constipation results from the pressure of the uterus on the rectum. Dr. M.E. Dirix wrote in 1869:

> Thus, women are treated for diseases of the stomach, liver, kidneys, heart, lungs, etc.; yet in most instances, these diseases will be found, on due investigation, to be, in reality, no disease at all, but merely the sympathetic reactions or the symptoms of one disease, namely, a disease of the womb.

The Psychology of the Ovary

If the uterus and ovaries could dominate woman's entire body, it was only a short step to the ovarian take-over of woman's entire personality. The basic idea, in the nineteenth century, was that female psychology functioned merely as an extension of female reproductivity, and that woman's nature was determined solely by her reproductive functions. The typical medical view was that "The ovaries . . . give to woman all her characteristics of body and mind." And Dr. Bliss remarked, somewhat spitefully, "The influence of the ovaries over the mind is displayed in woman's artfulness and dissimulation." According to this "psychology of the ovary," all woman's "natural" characteristics were directed from the ovaries, and any abnormalities – from irritability to insanity – could be attributed to some ovarian disease. As one doctor wrote, "All the various and

manifold derangements of the reproductive system, peculiar to females, add to the causes of insanity." Conversely, actual physical reproductive problems and disease, including cancer, could be traced back to bad habits and attitudes.

Masturbation was seen as a particularly vicious character defect that led to physical damage, and although this was believed to be true for both men and woman, doctors seemed more alarmed by female masturbation. They warned that "The Vice" could lead to menstrual dysfunction, uterine disease, and lesions on the genitals. Masturbation was one form of "hypersexuality," which was said to lead to consumption; in turn, consumption might result in hypersexuality. The association between "hypersexuality" and TB was easily "demonstrated" by pointing to the high rates of TB among prostitutes. All this fueled the notion that "sexual disorders" led to disease, and conversely, that disease lay behind woman's sexual desires.

The medical model of female nature, embodied in the "psychology of the ovary," drew a rigid distinction between reproductivity and sexuality. Woman were urged by the health books and the doctors to indulge in deep preoccupation with themselves as "The Sex"; they were to devote themselves to developing their reproductive powers, their maternal instincts, their "femininity." Yet they were told that they had no "natural" sexual feelings whatsoever. They were believed to be completely governed by their ovaries and uteruses, but to be repelled by the sex act itself. In fact, sexual feelings were seen as unwomanly, pathological, and possibly detrimental to the supreme function of reproduction. (Men on the other hand, *were* believed to have sexual feelings, and many doctors went so far as to condone prostitution on the grounds that the lust of upper-middle-class male should have outlets other than their delicate wives.)

The doctors themselves never seemed entirely convinced of this view of female nature. While they denied the existence of female sexuality as vigorously as any other men of their times, they were always on the lookout for it. Medically, this vigilance was justified by the idea that female sexuality could only be pathological. So it was only natural for some doctors to test for it by stroking the breasts or the clitoris. But under the stern disapproval, there always lurked the age-old fear of and fascination with woman's "insatiable lust" that, once awakened, might be totally uncontrollable. In 1853, when he was only twenty-five years old, the British physician Robert Brudenell Carter wrote (in a work entitled *On the Pathology and Treatment of Hysteria*):

> . . . no one who has realized the amount of moral evil wrought in girls . . . whole prurient desires have been increased by Indian hemp and partially gratified by medical manipulations, can deny that remedy is worse than disease. I have. . . seen young unmarried women, of the middle class of society, reduced by the constant use of the speculum to the mental and moral condition of prostitutes; seeking to give themselves the same indulgence by the practice of solitary vice; and asking every medical practitioner . . . to institute an examination of the sexual organs.

acceptable to the middle class by pointing out its possibilities for population control. In his 1912 presidential address to the AMA, Dr. Abraham Jacobi endorsed birth control, citing the high fertility of immigrants and the rising cost of welfare. Dr. Robert Dickinson, a gynecologicist and one of Sanger's most steadfast medical allies, urged his fellow doctors in 1916 to "take hold of this matter [birth control] and not let it go to the radicals." With the help of men like Dickinson, Ms. Sanger was able to begin the first birth control services – appropriately enough, in the slums of New York City.

Contraception did not become legal until a 1938 court ruling allowed physicians to import, mail, and prescribe birth control devices. This was a great step forward for women, and the credit goes largely to Margaret Sanger's courage and determination.

We want to be clear about our position on the issue. We think birth control should be available on demand for all *women, of all classes and ethnic groups. We do not subscribe to the view that birth control is liberating for some women, but "genocidal" for others. What we are criticizing is the line that the birth control movement advanced in order to make its gains. The fact that the birth control movement took a* racist *and* classist *line makes even the final victory a dubious one.*

But here we must ask ourselves: Could the birth control movement have succeeded any other way, given the context of American society at the time? If the birth control movement had advanced purely feminist arguments for contraception, would it have had the power or influence to succeed? We might ask a similar question about the public health movement: Would there have been any public health reforms if these had not been in the direct self-interest of wealthy and powerful people? These questions are, of course, unanswerable, but they do point to the fundamental ambiguity of reform *in an otherwise oppressive society.*

Women "Uplift" Women

The public health movement never succeeded in quarantining all the germ-ridden ghetto residents, and the birth control movement fell far short of its goals of race "purification." In fact, public health measures made the cities healthier for the poor as well as for the rich, and birth control, ironically, had its biggest impact on the population of the middle and upper classes themselves. Certainly, we owe a great deal to the masses of women who worked in these two movements, whatever their motivations. The sad thing is that the reform movements served to deepen the division of women along class lines: on the one side were the reformers (middle- and upper-middle-class women), on the other side the objects of reform (working-class women).

The reformers were women who rebelled against the empty leisure required of "ladies." They wanted to do something, wanted a project worthy of their untapped moral sensitivities and social concerns. For many, the project became the great task of "uplifting" working-class women. Public health and birth control were the more impersonal part of the campaign; many women reformers were drawn into direct contact with poor women. Anti-vice crusaders attempted to reform prostitutes; social workers went into the slums to teach the poor home

The Middle-Class Offensive: Birth Control

Public health was always respectable, but the birth control movement started out in the disreputable company of anarchists, socialists, and extreme feminists. Emma Goldman was jailed for speaking on birth control, and the young Margaret Sanger pushed it in her socialist/feminist journal *The Woman Rebel*. At first, other middle-class reformers saw birth control as a wicked scheme to "take penalty out of vice," and "degrade the wife to the level of the prostitute."

But as the movement matured under Sanger's single-handed leadership and attracted the support of thousands of upper-middle- and upper-class women, it began to make a frank appeal to upper-middle-class self-interest. By the late 1910s Sanger was blaming all the problems of the world – war, poverty, prostitution, famine, feeblemindedness – on overpopulation, and she put the blame for overpopulation squarely on women:

> While unknowingly laying the foundations of tyrannies and providing the human tinder for racial conflagration woman was also unknowingly creating slums, filling asylums with the insane, and institutions for other defectives. She was replenishing the ranks of prostitutes, furnishing grist for the criminal courts and inmates for prisons. Had she planned deliberately to achieve this tragic total of human waste and misery, she could hardly have done it more effectively.

And in case that did not make clear *which* women Sanger blamed, she wrote, in 1918, that "all our problems are the result of overbreeding among the working class."

Birth control offered the possibility of qualitative as well as quantitative control of the population. "More children for the fit, less for the unfit – that is the chief issue of birth control," Sanger declared in 1919. Just who was fit and who was unfit – and how you would impose birth control on one group and keep it away from the other – was not altogether clear. Ms. Sanger usually limited her definition of the "unfit" to the feebleminded (as judged by the newly invented IQ test), but some of her associates in the America Birth Control League were explicitly racist.

Guy Irving Burch, an officer of Sanger's National Committee on Federal Legislation for Birth Control, explained his interest in birth control thus:

> My family on both sides were early colonial and pioneer stock and I have long worked with the America Coalition of Patriotic Societies to prevent the American people from being replaced by alien or Negro stock, whether it be by immigration or by overly high birth rates among others in this country.

Another birth control advocate urged that "to offset the so-called 'yellow peril,'" the United States should, "spread birth control knowledge abroad so as to decrease the quantity of people whose unchecked reproduction threatens international peace."

A few farsighted physcians joined the campaign to make contraception

(Did Dr. Carter's patients actually smoke "Indian hemp" or beg for internal examinations? Unfortunately we have no other authority on the subject than Dr. Carter himself.)

Medical Treatments

Uninformed by anything that we could recognize today as a scientific description of the way human bodies work, the actual practice of medicine at the turn of the century was largely a matter of guesswork, consisting mainly of ancient remedies and occasionally daring experiments. Not until 1912, according to one medical estimate, did the average patient, seeking help from the average American doctor, have more than a fifty-fifty chance of benefiting from the encounter. In fact, the average patient ran a significant risk of actually getting worse as a result: bleeding, violent purges, heavy doses of mercury-based drugs, and even opium, were standard therapeutic approaches throughout the nineteenth century, for male as well as female patients. Even well into the twentieth century, there was little that we could recognize as modern medical technology. Surgery was still a highly risky enterprise; there were no antibiotics or other "wonder drugs"; and little was understood, medically, of the relationship between nutrition and health or of the role of hormones in regulating physiological processes.

Every patient suffered form this kind of hit-or-miss treatment, but some of the treatments applied to women now seem particularly useless and bizarre. For example, a doctor confronted with what he believed was an inflammation of the reproductive organs might try to "draw away" the inflammation by creating what he thought were counter-irritants – blisters or sores on the groin or thighs. The common medical practice of bleeding by means of leeches also took on some peculiar forms in the hands of gynecologists. Dr. F. Hollik, speaking of methods of curing amenorrhea (chronic lack of menstrual periods), commented: "Some authors speak very highly of the good effects of leeches, applied directly to the external lips [of the genitals], a few days before the period is expected." Leeches on the breasts might prove effective too, he observed, because of the deep sympathy between sexual organs. In some cases leeches were even applied to the cervix, despite the danger of their occasional loss in the uterus. (So far as we know, no doctor ever considered perpetrating similar medical insults to the male organs.)

Such methods could be dismissed as well intentions, if somewhat prurient, experimentation in an age of deep medical ignorance. But there were other "treatments" that were far more sinister – those aimed at altering female *behavior*. The least physically destructive of these was based, simply, on isolation and uninterrupted rest. This was used to treat a host of problems diagnosed as "nervous disorders."

Passivity was the main prescription, along with warm baths, cool baths, abstinence from animal foods and spices, and indulgence in milk and puddings, cereals, and "mild sub-acid fruits." Women were to have a nurse – not a relative

– to care for them, to receive no visitors, and as Dr. Dirix wrote, "all sources of mental excitement should be perseveringly guarded against." Charlotte Perkins Gilman was prescribed this kind of treatment by Dr. S. Wier Mitchell, who advised her to put away all her pens and books. Gilman later described the experience in a story "The Yellow Wallpaper," in which the heroine, a would-be writer, is ordered by her physician-husband to "rest":

> So I take phosphates or phosphites – whichever it is, and tonics and journeys, and air, and exercise, and am absolutely forbidden to "work" until I am well again.
> Personally, I disagree with their ideas. Personally, I believe that congenial work, with excitement and change, would do me good.
> But what is one to do?
> I did write for a while – in spite of them; but it does exhaust me a great deal – having to be so sly about it, . . . or else meet with heavy opposition.

Slowly Gilman's heroine begins to lose her grip ("It is getting to be a great effort for me to think straight. Just this nervous weakness, I suppose.") and finally she frees herself from her prison – into madness, crawling in endless circles about her room, muttering about the wallpaper.

But it was the field of gynecological surgery that provided the most brutally direct medical treatments of female "personality disorders." And the surgical approach to female psychological problems had what was considered a solid theoretical basis in the theory of the "psychology of the ovary." After all, if a woman's entire personality was dominated by her reproductive organs, then gynecological surgery was the most logical approach to any female psychological problem. Beginning in the late 1860s, doctors began to act on this principle.

At least one of their treatments probably was effective: surgical removal of the clitoris as a cure for sexual arousal. A medical book of this period stated: "Unnatural growth of the clitoris . . . is likely to lead to immorality as well as to serious disease. . . amputation may be necessary." Although many doctors frowned on the practice of removing the clitoris, they tended to agree that this might be necessary in cases of "nymphomania." (The last clitorectomy we know of in the United States was performed twenty-five years ago on a child of five, as a cure for masturbation.)

More widely practiced was the surgical removal of the ovaries – ovariotomy, or "female castration." Thousands of these operations were performed from 1860 to 1890. In his article "The Spermatic Economy," Ben Barker-Benfield described the invention of the "normal ovariotomy," or removal of the ovaries for non-ovarian conditions – in 1872 by Dr. Robert Battey of Rome, Georgia.

> Among the indications were a troublesomeness, eating like a ploughman, masturbation, attempted suicide, erotic tendencies, persecution mania, simple "cussedness," and dysmenorrhea. Most apparent in the enormous variety of symptoms doctors took to indicate castration was a strong current of sexual appetitiveness on the part of the women.

Nation, calling for public health police powers to hunt down an estimated 20,000 "loose" TB victims:

> It is as if the enemy had stolen through the pickets at night and there were no police or soldiers to follow them. The tubercle bacilli swarm through the city on silent wings, grimly laughing at the pamphlets and lecture and scattered deeds of charity which they find so easy to elude.

Public health crusaders were perfectly frank about their class interests in reform. The National Association for the Study and Prevention of Tuberculosis presented detailed calculations of the costs of TB among the poor to the middle class – in terms of absenteeism by workers, relief required for orphans, etc. In a more lyrical vein, Mrs. Plunkett, the household hygiene expert, asked how the problem of poverty and disease was to be solved, and answered her own question:

> Through the agency of *enlightened selfishness* . . . the upper 10,000 are learning that their sanitary welfare is indissolubly connected to that of the lower 10 millions, and it is this perception of this truth that has caused the "wave of emotional interest" in the condition of the poorer classes. . . . The class to be elevated resent supervision and care little for health or cleanliness till taught but already some great and definite steps have been taken.

In the war against dirt and germs it was only natural that women should take the lead. Weren't women the divinely appointed sanitation officers of their own homes? In 1881 an American household hygiene book quoted the president of the British Medical Association (at the time probably more prestigious here than the AMA) as placing almost full responsibility for health on "the character of the presiding genius of the home, or the woman who rules over that small domain." But woman's sanitary responsibilities obviously could not end at her doorstep. In his thesis on nineteenth century "social purity" movements, David Pivar writes:

> Women of the middle class believed in high standards of sanitation and cleanliness and feared the contagions located in the slums and on the streets. Long dresses, dragging the muck, transported dirt, dust and germs into the home. Clothing manufactured in tenement houses found its way into middle class homes. Disease could not be stopped with a closed door. If the home was to be protected, women would not turn inward; they were forced to make the community more "home-like." Only through improvements in public health and morals could the sanctity of the home be assured.

Woman doctors entered the Public Health in disproportionate numbers (partially because it was easier for a woman to enter public health than to set up in private practice). At the grass-roots level, public health was very much a women's movement (of upper-middle-class women) with close ties to the temperance and suffrage movements.

The Middle-Class Offensive: Public Health

Beginning in the last decades of the nineteenth century, the "better" classes launched an organized political offensive against poor and working people. There were repressive anti-labor measures, civic "reforms" aimed at reducing the electoral power of immigrant groups, and, later, laws to stop the immigration of Italians, Jews, Poles, and other "inferior" races. In the *biological* class warfare, the two major middle-class thrusts were the public health movement and the birth control movement, directed against the twin threats of contagion and "outbreeding," respectively. Both of these movements drew heavily upon the energies of middle- and upper-middle-class woman who, as our historical period wore on, were becoming increasingly dissatisfied with the life of enforced leisure.

The progressive achievements of these movements are obvious: legal contraception, free garbage removal, compulsory immunization, to name just a few. But their story as social movements is somewhat more ambiguous: both mobilized large numbers of middle- and upper-class women in a way which solidified their new relationship to working-class women – not as sisters, but as *uplifters*.

The public health movement had an evangelical tone which put it in the same moral league with the temperance [anti-alcohol] and "social purity" (anti-prostitution) movements. In fact, the distinction between "dirt" and "sin" was still unclear. An earlier generation had traced all disease to immorality and relied on prayer rather than sanitation to ward off epidemics. The sin theory of disease provided a comforting explanation of why epidemics were most virulent in the areas inhabited by "vicious, intemperate, and atheistic" immigrant workers. But the theory was not so comforting when it became clear that epidemics could also carry off bankers, ministers, and society ladies. The blame shifted from sin to "dirt," but the moral implications hardly changed. Typhoid epidemics, according to the household hygiene book we cited earlier, had been looked upon as "chastening visitations of God for moral delinquencies," but in the light of contemporary sanitary "sciences," were recognized as "the strict adjustments of penalty for His broken physical laws." Dr. Elizabeth Blackwell called sanitation "the *reverential* acceptance of the *divine* laws of health" (emphasis added).

The moral aspect of public health was also reflected in its strong bureaucratic ties to the police. In New York City, which set the pattern for public health administration in other cities, public health was originally a police function, and the first Metropolitan Board of Health included equal numbers of doctors and police officials. The association between public health and police functions (crime and disease) was strengthened by the realization in the latter part of the first decade of the twentieth century that people – not books, coins or breezes – were the main carriers of disease. Then public health officers began to take on police functions themselves, tracking down and quarantining (as in the case of Typhoid Mary) characters suspected of spreading disease. The crime-fighting zeal of the public health officials comes through clear in a 1910 article in *The*

Patients were often brought in by their husbands, who complained of their unruly behaviors. When returned to their husbands, "castrated," they were "tractible, orderly, industrious and cleanly," according to Dr. Battey. (Today ovariotomy, accompanying a hysterectomy, for example, is not known to have these effects on the personality. One can only wonder what, of any, personality changes Dr. Battey's patients really went through.) Whatever the effects, some doctors claimed to have removed from fifteen hundred to two thousand ovaries; in Barker-Benfield's words, they "handed them around at medical society meetings on plates like trophies."

We could go on cataloging the ludicrous theories, the lurid cure, but the point should be clear: late nineteenth century medical treatment of women made very little sense as *medicine*, but it was undoubtedly effective at keeping certain woman – those who could afford to be patients – in their place. As we have seen, surgery was often performed with the explicit goal of "taming" a high-strung woman, and whether or not the surgery itself was effective, the very threat of surgery was probably enough to bring many women into line. Prescribing bed rest was obviously little more than a kind of benign imprisonment – and the prescription prohibiting intellectual activities speak for themselves!

But these are just the extreme "cures." The great majority of upper-middle-class women were never subjected to gynecological surgery or long-term bed rest, yet they too were victim of the prevailing assumptions about woman's "weakness" and the necessity of frequent medical attention. The more the doctors "treated," the more they lured women into seeing themselves as sick. The entire mystique of female sickness – the housecalls, the tonics and medicines, the health spa – served, above all, to keep a great many women busy at the task of doing nothing. Even among middle-class women who could not afford constant medical attention and who did not have the leisure for full-time invalidism, the myth of the female frailty took its toll, with cheap (and often dangerous) patent medicines taking the place of high-priced professional "cures."

One very important effect of all this was a great increase in the upper-middle-class woman's dependance on men. To be sure, the leisured lady of the "better" classes was already financially dependent on her husband. But the cult of invalidism made her seem dependent for her very physical survival both on her doctor and her husband. She might be tired of being a kept woman, she might yearn for a life of meaning and activity, but if she was convinced that she was seriously sick or in danger of becoming so, would she dare to break away? How could she even survive on her own, without the expensive medical care paid for by her husband? Ultimately, she might even become convinced that her restlessness was itself "sick" – just further proof of her need for a confined, inactive life. And if she did overcome the paralyzing assumption of women's innate sickness and begin to act in unconventional ways, a doctor could always be found to prescribe a return to what was considered normal.

In fact, the medical attention directed at these women amounted to what may have been a very

effective surveillance system. Doctors were in a position to detect the first signs of rebelliousness, and to interpret them as symptoms of a "disease" which had to be "cured."

Subverting the Sick Role

It would be a mistake to assume that women were merely the passive victims of a medical reign of terror. In some ways, they were able to turn the sick role to their own advantage, especially as a form of birth control. For the "well-bred" woman to whom sex really *was* repugnant, and yet a "duty," or for any woman who wanted to avoid pregnancy, "feeling sick" was a way out – and there were few others. Contraception methods were virtually unavailable; abortion was risky and illegal. It would never have entered a respectable doctor's head to advise a lady on contraception (if he *had* any advice to offer, which is unlikely). Or to offer to perform an abortion (at least according to AMA propaganda). In fact, doctors devoted considerable energy to "proving" that contraception and abortion were inherently unhealthy, and capable of causing such diseases as cancer. (This was before the pill!) But a doctor *could* help a woman by supporting her claims to be too sick for sex; he could recommend abstinence. So who knows how many of this period's drooping consumptive and listless invalids were actually well women, feigning illness to escape intercourse and pregnancy?

If some women resorted to sickness as a means of birth – and sex – control, others undoubtedly used it to gain attention and a limitless measure of power with their families. Today, everybody is familiar with the (sexist) myth of the mother-in-law whose symptoms conveniently strike during family crisis. In the nineteenth century, women developed, in epidemic numbers, an entire syndrome which even doctors sometimes interpreted as a power grab rather than a genuine illness. The new disease was hysteria, which in many ways epitomized the cult of female invalidism. It affected upper- and upper-middle-class women almost exclusively; it has no discernible organic basis; and it was totally resistant to medical treatment. For those reasons alone, it is worth considering in some detail.

A contemporary doctor described the hysterical fit this way:

> The patient. . . loses the ordinary expression of countenance, which is replaced by a vacant stare; becomes agitated; falls if before standing; throws limbs about convulsively; twists the body into all kinds of violent contortions; beats her chest; sometimes tears her hair; and attempts to bite herself and others; and, though a delicate woman, evinces a muscular strengthen which often requires four or five persons to restrain her effectually.

Hysteria appeared, not only as fits and fainting, but in every other form: hysterical loss of voice, loss of appetite, hysterical coughing or sneezing, and, of course, hysterical screaming, laughing, and crying. The disease spread wildly, yet almost exclusively in a select clientele of urban middle- and upper-middle-class white women between the ages of fifteen and forty-five.

Doctors became obsessed with this "most confusing, mysterious and

wives, and dragging the erring males to ruin. Prostitution had not been a problem in the nation's youth, but urbanization and poverty made it a booming industry in the late nineteenth and early twentieth centuries. To reform-minded citizens (many of them women's rights activists), prostitution was much more than a public health problem, it was *the* Social Evil, underlying municipal corruption, family breakdown in the lower classes, and public immorality in general.

Some of the best data we have in the extent of prostitution and VD during the first decades of the century come from a series of studies sponsored by John D. Rockefeller Jr.'s Bureau of Social Hygiene (a private, voluntary agency). According to one of the Bureau reports, prepared by Dr. Howard Woolston, alarm reached a peak in the 1910s when the prospect of U.S. involvement in the First World War "brought home to the American people as nothing in our previous history had ever done, the menace of prostitution and venereal disease to the young manhood of our country."

By 1917 (the date of this report), police efforts had already cut severely into the trade, and yet Dr. Woolston found 200,000 women "in the regular army of vice," an estimated 60 to 75 percent of them carrying VD. As a result, an estimated 25 to 35 percent of the adult urban population were infected. Not only laboring men with their "animal pleasures," but also businessmen, college boys, and professional men were among the victims.

Only the most enlightened – feminists and social reformers – traced prostitution to poverty and oppressive sex roles. Moralists blamed "male lust and female frailty." More "scientific" observers blamed the prostitute herself or, rather, her "congenital defects." In the 1917 study Dr. Woolston went out to discount economic motivations in prostitutes, and seriously concluded that "the ordinary prostitute appears to be a short, stocky woman." further, at least one third of them were mentally defective:

> It is a well-known fact that feeblemindedness is hereditary. Consequently, some of the mental abnormalities of the prostitutes can be directly traced to weakness in the stock from which they come. . . . In 297 of the 1,000 families [of prostitutes surveyed] . . . some actively viscous or clearly recognized degenerate strain was known to be present. It is likely that a more complete investigation would have revealed an even larger number.

However, prostitutes were not seen as a breed apart from the average working-class woman. Dr. Woolston and other surveyors found that there was considerable shuttling back and forth between prostitution and low-paid jobs such as domestic service. In the popular imagination, working-class women were all somewhat sickening, whether because they spread diseases or dragged down the "race" with their inferior and all-too-plentiful offspring. If the upper-middle-class woman had health problems, the working-class woman was a health problem. Not for her the domineering and indulgent physician; for her there was the public health officer.

of. One couldn't go without them, but could one trust them? A survivor of the early decades of the twentieth century told us: "If anything was missing, like a piece of silverware, the servants must have taken it. If anyone in the family got sick, you naturally suspected the servants of carrying something."

The cases of "Typhoid Mary" riveted public attention on the dangers of contagion from domestic servants. From a brief account of this case one can appreciate its dramatic impact.

Mary Mallon was an Irish-American cook who worked the silk-stocking districts – Oyster Bay, Park Avenue, Sands Point, Dark Harbor, Maine. Her references were good, her employers liked her cooking and were frequently impressed by her steadfastness in the face of family disaster, which seemed to be a routine feature of Ms. Mallon's life.

When she was finally locked up in 1915, she had left a trail of fifty-two typhoid cases, three of them fatal, in the homes of her employers. Her employers had always tended to blame some other servant in their houses for the typhoid outbreaks, until the relentless detective work of the New York City Health Department exposed Ms. Mallon as the culprit. The lab tests proved it: She was a typhoid germ carrier who did not herself suffer from the disease. She was first apprehended in 1907 and placed in solitary quarantine on a tiny island in the East River, then after three years released on parole on the condition that she give up cooking. In 1913 she broke parole and vanished, only to turn up two years later – cooking again – in a Queens hospital struck by typhoid.

Ms. Mallon always insisted that she had never had typhoid fever, was not a typhoid carrier, and was the innocent scape-goat of publicity-hungry health officials. When the health officials came to get her 1907, she first resisted with a carving fork, then escaped through a back window and barricaded herself with barrels. She was whisked off by car to the public health laboratory with eminent public health authority Dr. Josephine Baker sitting on her chest to subdue her. Her final capture in 1915 was, according to the New York Times*, "nearly as lively as her first one," featuring another chase through windows and backyards.*

Here was biological guerrilla warfare at its most virulent. Newspapers' Sunday supplements caricatured Ms. Mallon as a fiend popping human skulls into a skillet while the *New York Times* solemnly explained the dangers of hiring servants without thoroughly investigating references. Typhoid Mary survived in folklore as a symbol of the "sickening" woman who poisons everything she touches.

Of course, we now know that, as a typhoid carrier, she was a medical anomaly, a weird exception. Yet to middle-class people of her day she epitomized the threat that *all* working-class women represented: they might *look* innocently robust and healthy, but who knows, what dreaded disease they harbored.

Prostitutes and Venereal Disease

Although servants and working-class women in general were all faintly suspect, no one excited middle-class germ fears like the prostitute. Prostitution represented a reservoir of hideous disease, perpetually spilling over onto the families of decent people; infecting the fetus in the womb, crippling innocent

rebellious of diseases." In some ways, it was the ideal disease for the doctors: it was never fatal, and it required an almost endless amount of medical attention. But it was not an ideal disease from the point of view of the husband and family of the afflicted woman. Gentle invalidism was one thing; violent fits were quite another. So hysteria put the doctors on the spot. It was essential to their professional self-esteem either to find an organic basis for the disease, and cure it, or to expose it as a clever charade.

There was plenty of evidence for the latter point of view. With mounting suspicion, medical literature began to observe that hysterics never had fits when alone, and only when there was something soft to fall on. One doctor accused them of pinning their hair in such a way that it would fall luxuriantly when they fainted. The hysterical "type" began to be characterized as a "petty tyrant" with a "taste for power" over her husband, servants and children, and, if possible, her doctor.

In historian Carroll Smith-Rosenberg's interpretation, the doctor's accusations had some truth to them: the hysterical fit, for many women, must have been the only acceptable outburst – of rage, or despair, or simply of *energy* – possible. But as a form of revolt it was very limited. No matter how many women might adopt it, it remained completely individualized: hysterics don't unite and fight. As a power play, throwing a fit might give a brief psychological advantage over a husband or a doctor, but ultimately it played into the hands of the doctors by confirming their notion of women as irrational, unpredictable, and diseased.

On the whole, however, doctors did continue to insist that hysteria was a real disease – a disease of the uterus, in fact. (Hysteria comes from the Greek word for uterus.) They remained unshaken in their conviction that their own house calls and high physician's fees were absolutely necessary; yet at the same time, in their treatment and in their writing, doctors assumed an increasingly angry and threatening attitude. One doctor wrote, "It will sometimes be advisable to speak in a decided tone, in the presence of the patient, of the necessity of shaving the head, or of giving her a cold shower bath, should she not be soon relieved." He then gave a "scientific" rationalization for this treatment by saying, "The sedative influence of fear may allay, as I have known it to do, the excitement of the nervous centers. . . ."

Carroll Smith-Rosenberg writes that doctors recommended suffocating hysterical women until their fits stopped, beating then across the face and body with wet towels, and embarrassing them in front of family and friends. She quotes Dr. F.C. Skey: "Ridicule to a woman of sensitive mind, is a powerful weapon. . . but there is not an emotion equal to fear and threat of personal chastisement. . . . They will listen to the voice of authority." The more women became hysterical, the more doctor's became punitive towards the disease; and at the same time, they began to see the disease everywhere themselves until they were diagnosing every independent act by a woman, especially women's rights actions, as "hysterical."

With hysteria, the cult of female invalidism was carried to its logical conclusion. Society had assigned affluent women to a life of confinement and inactivity, and medicine had justified this assignment by describing women as innately sick. In the epidemic of hysteria, women were both accepting their inherent "sickness" *and* finding a way to rebel against an intolerable social life. Sickness, having become a way of life, became a way of rebellion, and medical treatment, which had always had strong overtones of coercion, revealed itself as frankly and brutally repressive.

But hysteria is more than a bizarre twist of medical history. The nineteenth century epidemic of hysteria had lasting significance because it ushered in a totally new "scientific" approach to the medical management of women.

While conflict between women and their doctors in America was escalating on the issue of hysteria, Sigmund Freud, in Vienna, was beginning to work on a treatment that would remove the disease altogether from the arena of gynecology. In one stroke, he solved the problem of hysteria and marked out a new medical specialty. "Psychoanalysis," as Carroll Smith-Rosenberg has said, "is the child of the hysterical woman." Freud's cure was based on changing the rules of the game: in the first place, by eliminating the issue of whether or not the woman was faking. Psychoanalysis, as Thomas Szasz has pointed out, insists that "malingering is an illness – in fact, an illness 'more serious' then hysteria." Secondly, Freud established that hysteria was a mental disorder. He banished the traumatic "cures" and legitimized a doctor-patient relationship based solely on talking. His therapy urged the patient to confess her resentments and rebelliousness, and then at last to accept her role as a woman.

Under Freud's influence, the scalpel for the dissection of female nature eventually passed from the gynecologists to the psychiatrist. In some ways, psychoanalysis represented a sharp break with the past and a genuine advance for women to have sexual feelings (although only vaginal sensations were believed to be normal for adult women; clitoral sensation was "immature" and "masculine"). But in important ways, the Freudian theory of female nature was in direct continuity with the gynecological view which it replaced. It held that the female personality was inherently defective, this time due to the absence of a penis, rather than the presence of the domineering uterus. Women were still "sick," and their sickness was still totally predestined by their anatomy.

In 1903, President Theodore Roosevelt thundered to the nation the danger of "race suicide":

> Among human beings, as among all living creatures, if the best specimens do not, and the poorer specimens do, propagate, the type [race] will go down. If Americans of the old stock lead lives of celibate selfishness . . . or if the married are afflicted by that base fear of living which, whether for the sake of themselves or their children, forbids them to have more than one or two children, disaster awaits the nation.

He was not against contraception on principle, granting that "doubtless there are communities which it would be in the interest of the world to have died out," but for middle- and upper-middle-class WASP women, it was downright unpatriotic.

The Special Danger of Working-Class Women

As strikers, rioters, or terrorists, working-class men were usually at the forefront of overt political class struggle. Working-class women, on the other hand, were seen as leading the insidious biological warfare. As breeders, they seemed to outdo the delicate or "high-strung" ladies of the better classes. As disease carriers, they were regarded as especially dangerous because they were likely – much more than working-class males– to come into close contact with affluent people. While the men were safely quarantined in heavy industry, the women sought jobs in some of the niches left by leisured females of the middle and upper classes. "Ladies" no longer did their own sewing or housekeeping and were far too well mannered to satisfy their husbands' sexual appetites. So fields such as domestic service, garment manufacture, and prostitution were wide open to the working-class women.

Wherever working-class women, or their products, entered the homes of "better" classes, could germs be far behind? Garments sewn in tiny tenement sweatshops were suspected of carrying disease germs into wealthy homes, and the garment workers' union played up to this fear by urging people to buy union label clothes because they were made in "hygienic" factories rather than unsupervised tenement shops. The winner of the America Federation of Labor's essay prize on "The Union Label" (c. 1912) wrote: "The union label is, indeed, the only guarantee that the products of any industry are fit to enter decent and cleanly homes." What the union had in mind of course, was that consumers' interest in hygiene would lead them to support the workers' cause, but this strategy sometimes backfired. AFL President Samuel Gompers complained in 1903 that certain consumer groups composed of "well-meaning philanthropic ladies" were issuing their own labels on the basis of sanitation alone, with no regard for the wages, working conditions, or hours of the women workers, and sometimes even in competition with the workers' own label!

Domestic servants, "strangers within our gate," were not so easily disposed

millionaire or a shillingaire, with a perfectly leveling and democratic impartiality.

The germ theory of disease, which became known to the public in the 1890s (in somewhat distorted fashion), supplied a more concrete basis for class fears about contagion. No longer could abstract "filth," miasmas, or divine will be blamed for disease. There were real, material germs, transmitted by human beings and the objects they touched. Americans, who only a generation ago had feared that bathing was harmful, became preoccupied with germs. The reason people gave for avoiding the ghetto was not the risk of being mugged, but that of being infected with disease. In fact, any public place or object was suspect, as these popular magazine article titles from the period 1900 to 1904 suggest: "Books Spread Contagion," "Contagion by Telephone," "Infection and Postage Stamps," "Disease from Public Laundries," "Menace of the Barber Shop."

There was, certainly, some rational basis for the fear of the poor as a source of contagion. Rates of infectious diseases were higher among the poor, and since scientists themselves were not sure how germs were transmitted, it probably seemed safest just to avoid contact with the poor as much as possible. But for our purposes, the distinction between intelligent caution and outright prejudice is not very important. The point is that middle- and upper-middle-class people frequently expressed their fear of the poor as a fear of germs, just as white people today might say they don't mind contact with blacks per se; it's crime (or drugs) they're afraid of.

The second front in the biological class warfare features nor germs, but genes. An optimistic reading of Darwin suggested that the "better" class of people would soon outnumber, as well as dominate, the less fit. Poverty was its own cure; epidemic disease among the poor were the ultimately benign instrument of natural selection. (In 1870s an observer pointed out that the race problem would soon solve itself. Living in abject poverty in northern cities, freed slaves seemed to be rapidly headed for extinction.) But by the turn of the century it began to seem as if, by some monstrous aberration of natural law, the better classes were doomed for extinction.

The birthrate among WASP Americans had been falling since about 1820. Immigrants and blacks, despite their much higher death rates, were believed to be breeding prolifically. Edwards Ross, an early twentieth-century writer who was a liberal for his time, connected the immigrants' fecundity to "their coarse peasant philosophy of sex," "their brawls and their animal pleasures." All this was abhorrent to people of delicacy, but so was the prospect of extinction.

A Professor Edwin Conklin, of Princeton, wrote in the 1890s:

> The cause for alarm is the declining birth rate among the best elements of a population, while it continues to increase among the poorer elements. The descendants of the Puritans and the Cavaliers. . . are already disappearing, and in a few centuries at most, will have given place to more fertile races. . . .

The Sickening Women of the Working Class

While doctors were manufacturing ills for affluent women, living conditions in the growing urban slums were making life actually hazardous for poor women. Tenements, which sometimes provided a single privy for dozens of families, were fertile breeding places for typhoid, yellow fever, TB, cholera, and diphtheria. Women who worked outside the homes often put in ten or more hours a day in crowded, poorly ventilated factories or sweatshops, which the constant danger of fatal or disfiguring industrial accidents.

A woman who worked in the garment industry between 1900 and 1910 described her working conditions as follows:

> I see again the dangerously broken stairways in practically all these so-called factories. The windows few and so dirty that rarely did the sun's rays penetrate these interiors. The wooden floors that were swept once a year. . . . No dressing rooms save the filthy, malodorous lavatory in the dark hall. No fresh drinking water save the cheap soda sold by the poor old peddler. Workshops wherein mice and roaches were as much a part of the physical surroundings as were the machines and the humans. . . .

Sickness, exhaustion, and injury where routine in the life of the working-class woman. Contagious diseases always hit the homes of the poor first and hardest. Pregnancy, in a fifth- or sixth-floor walk-up flat, really was debilitating, and childbirth, in a crowded tenement room, was often a frantic ordeal. Emma Goldman, who was a trained midwife as well as an anarchist leader, described "the fierce, blind struggle of the women of the poor against frequent pregnancies" and told of the agony of seeing children grow up "sickly and undernourished" – if they survived infancy at all. For the woman who labored outside her home, working conditions took an enormous toll. An 1884 report of an investigation of "The Working Girls of Boston," by the Massachusetts Bureau of Statistics of Labor, stated:

> . . . the health of many girls is so poor as to necessitate long rests, one being out a year on this account. Another girl in poor health was obligated to leave her work, while one reports that it is not possible for her to work the year round, as she could not stand the strain, not being at all strong. A girl. . . was obligated to leave on account of poor health, being completely run down from badly ventilated rooms, and obligated to take an eight months rest; she worked a week when not able, but left to save her life. She says she has to work almost to death to make fair compensation (now $12 per week).

Still, however sick or tired working-class women might have been, they certainly did not have the time or money to support a cult of invalidism. Employers gave no time off for pregnancy or recovery from childbirth, much less for menstrual periods, though the wives of these same employers often retired to bed on all these occasions. A day's absence from work could cost a

woman her job, and at home there was no comfortable chaise longue to collapse on while servants managed the household and doctors managed the illness. Two women who worked in the garment industry remembered:

> We only went from bed to work and from work to bed again. . . and sometimes if we sat up a little while at home we were so tired we could not speak to the rest and we hardly knew what we were talking about. And still, there was nothing for us but bed and machine, we could not earn enough to take care of ourselves through the slack season.

Doctors, who zealously indulged the ills of wealthy patients, had no time to spare for the poor. Lilian Wald, a nurse who set up her own practice in New York's Lower East Side, wrote of the troubles she had in finding a doctor to visit a dying woman in the slums. When Emma Goldman asked the doctors she knew whether they had any contraception information she could offer the poor, their answers included, "The poor have only themselves to blame; they indulge in their appetites too much," and, "When she [the poor woman] uses her brains more, her procreative organs will function less." By and large, medical care for the poor meant home remedies or patent medicines. Only those too far gone to protest would make the trip to a public hospital where inadequate nursing and unsanitary conditions actually diminished one's chance of survival.

If there was no public outcry about the health of poor women, there was a great deal of upper- and middle-class concern about what the poor were doing to the "health" of the cities.

Americans liked to pride themselves on having a classless society, but there was no way to ignore the fact of increasing class polarization in the cities, where the gracious homes of the affluent were often less than a trolley ride away from such notorious slums as New York's Hell's Kitchen or Lower East Side, or Boston's North Side. There had always been poor people, of course, but there had never been so many of them, and they had never been so visibly different from everyone else. Waves of immigration from southern and eastern Europe had created a working class that had its own distinct languages and customs. By the late nineteenth century immigrant workers outnumbered "native Americans" in the major industrial cities – New York, Cleveland, and Chicago. Cities that had once been peaceably middle class became scenes of epidemics, vice, municipal corruption, and – most frightening of all – riots and violent strikes. The causes of working-class unrest were easy enough to see, for anyone who wanted to see them, but it was simpler and more comfortable to blame the poor themselves. As disruption led to repression, and repression fueled new disruption, wealthier people began to have a sense of being beleaguered in there own land – surrounded by the unwashed, unruly, "un-American" poor.

Class struggle – in the eyes of an increasingly smug and prosperous middle class – was unnatural, un-American, something that only happened "over there" in decadent Europe. Fortunately, "science" provided terms in which class polarization could be talked about without any damage to national pride. The

main idea, that the poor were "naturally" inferior, was remarkably parallel to medical theories about women.

First, there was Darwin's theory of evolution, which conveniently hit popular consciousness in the 1860s and 1870s, just in time to explain the developing class polarization. If some people had more than others – more money, more leisure, better housing, etc. – this was just another cases of the workings of that great and natural law: the survival of the fittest. It would be more "unscientific" to see poverty as the result of social injustice when it was only Nature's way of singling out the manifestly "unfit."

In view of Nature's grand evolutionary purpose, the rebelliousness of the poor was, at best, short-sighted. More commonly, it was seen as an infraction of natural law, i.e., a disease. Contemporary metaphors of class struggle drew as heavily from medicine as from Marx. For example, a writer in a business magazine declared just after the 1886 Haymarket riot that anarchy was a "blood disease" for which, apparently, only Americans of Yankee stock were exempt.

In 1885 a leading minister called for a rational approach to labor unrest, which was fundamentally "physiological" in origin. Race problems came in for the same treatment, the most farfetched example being Dr. Samuel A. Cartwritght's pre-Civil War theory that the tendency of slaves to run away was due to a congenital blood disorder – which he dignified with the Latin name "drapetomania" (curable, needless to say, by hard work and whippings). Just as gynecologists found female restlessness to be a symptom of a basic ovarian malfunction, so did social observers see the poor as a "race" afflicted with pathological rebellious tendencies.

Biological Class Warfare

Social Darwinism was a comforting ideology for those on top, but it never quite dispelled the fear that, by some irony of natural history, the poor might win out in the new biological class warfare. First, there was the danger of contagion from the poor. Disease was invariably seen as foreign in origin – imported on immigrant ships and bred in immigrant slums. In mid-century, an ex-mayor of New York wrote in his diary that the immigrants were:

> filthy, intemperate, unused to the comforts of life and regardless of its proprieties. . . . [They] flock to the populous towns of the great west, with disease engendered on shipboard, and increased by bad habits on shore, they inoculate the inhabitants of these beautiful cities.

In her household hygiene book (*Women, Plumbers and Doctors, or Household Sanitation*, 1885) Mrs. H.M. Plunkett warned:

> A man may live on the splendid "avenue," in a mansion plumbed in the latest and costliest style, but if half a mile away, in range with his open window, there is a "slum," or even a neglected tenement house, the zephyrs will come along and pick up the disease germs and bear them onwards, distributing them to whomsoever it meets, whether he be a